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IN THE SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1995

JANETTE M. WIFE OF/AND CHARLIE KORNMAN, INDIVIDUALLY AND ON BEHALF OF THEIR DEPENDENT SON, RICHARD JAY KORNMAN

VERSUS

BLUE CROSS/BLUE SHIELD OF LOUISIANA

PETITION FOR WRIT OF CERTIORARI TO THE SUPREME COURT OF THE STATE OF LOUISIANA

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QUESTIONS PRESENTED

I. Whether the Supreme Court of the State of Louisiana and other Louisiana courts erred in refusing to and not following the decisions, guidelines and/or standards used or established by the United States Court of Appeal, Fifth Circuit for determining whether an employer established medical expense plan for employees is a plan covered by the Employee Retirement Income Security Act, 29 U.S.C. §1001 et seq. (ERISA). The decision of the Supreme Court of the State of Louisiana in upholding a decision of the Louisiana Court of Appeal, Fifth Circuit is in direct conflict with decisions of the United States Court of Appeal, Fifth Circuit, on the same issue.

LIST OF PARTIES

In accordance with Supreme Court Rule 14(b), petitioner submits the following list of all parties to the proceeding in the Supreme Court of Louisiana, whose judgment is sought to be reviewed. The parties are, to-wit:

A. List of Petitioners

1. Louisiana Health Service and Indemnity Company (Blue Cross/Blue Shield of Louisiana) (erroneously referred to in plaintiff's proceedings as "Blue Cross/ Blue Shield of Louisiana")

B. List of All Other Parties

2. Janette M. Kornman

3. Charlie Kornman

4. Richard Jay Kornman

5. Estate of Charlie Kornman

6. Janette M. Kornman, Executrix of the Estate of Charlie Kornman

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NO.

IN THE SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1995

PETITION FOR WRIT OF CERTIORARI TO THE SUPREME COURT OF THE STATE OF LOUISIANA

The petitioner, Louisiana Health Service and Indemnity Company (Blue Cross/Blue Shield of Louisiana), respectfully prays that a writ of certiorari issue to review the Judgment of the Supreme Court of the State of Louisiana entered February 16, 1996.

CITATIONS OF THE OFFICIAL OPINIONS ENTERED IN THIS CASE BY COURTS

1. The opinion of the Supreme Court of Louisiana denying an Application for Writ of Certiorari and/or Review to review the opinion of the Louisiana Court of Appeal, Fifth Circuit, is reported at 667 So.2d 1054 (Appendix A)

2. The opinion of the Louisiana Court of Appeal, Fifth Circuit, is reported at 662 So.2d 498 (Appendix B)

JURISDICTION

The Judgment of the Supreme Court of the State of Louisiana was entered on February 16, 1996. No petition or application for rehearing was filed since pursuant to its rules, Rule IX, Section 6 (Appendix J) the Supreme Court of the State

of Louisiana will not consider a rehearing when it denies an application for a writ of certiorari and/or review. The jurisdiction of this Honorable Court is invoked under 28 U.S.C. §1257(a)

STATUTORY PROVISIONS INVOLVED

The statute involved in this case is the Employee Retirement Income Security Act, 29 U.S.C. §1001, et seq. (ERISA), more specifically Section 1002(1) of ERISA, 29 U.S.C. §1002(1), which provides in relevant part:

> For the purposes of this subchapter:
>
> (1) The terms "employee welfare benefit plan" and "welfare plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 186(c) of this title (other than pensions on retirement or death, and insurance to provide such pensions).

STATEMENT OF THE CASE

This suit was originally brought in the Twenty-Fourth Judicial District Court for the Parish of Jefferson, State of Louisiana, and was given the number 364-688 on the docket of

that court. The original plaintiffs in the suit were Charlie Kornman and his wife, Janette Kornman. They filed suit on their behalf and on behalf of their alleged dependent son, Richard Kornman. At the time suit was filed Richard Kornman was 28 years old. Richard Kornman was later added as a party-plaintiff, and after Charlie Kornman's death, the Succession of (estate of) Charlie Kornman represented by Janette Kornman, Executrix of the Estate of Charlie Kornman, was substituted as a party-plaintiff. All of the plaintiffs are hereinafter referred to collectively as "Kornmans".

Charlie Kornman was one of twenty (20) or more employees of Coast Quality Construction Corporation ("Coast"). Coast created, maintained and provided to its twenty (20) or more employees a medical expense plan ("Coast MEP") and made application to Louisiana Health Service & Indemnity Company (Blue Cross/Blue Shield of Louisiana) (hereinafter "Blue Cross") to insure the plan. The purpose of the plan was to provide health benefits for the employees and provide for payment of medical expenses incurred by the employees of Coast. The plan provided that, when an employee made a claim for medical benefits under the plan, a determination would be made whether or not the plan provided coverage and payment of the medical expenses set forth in the claim. The plan further provided that, if an employee disputed the decision as to coverage and/or payment of a claim, then the employee might appeal to Blue Cross' ERISA review department. (See Appendix I) The undisputed facts in this case are that Coast arranged the plan, determined what medical benefits the plan would provide, determined that it would be a plan insured by Blue Cross and what would be insured by Blue Cross. Coast was billed directly for all premiums and fees due under the agreement with Blue Cross, and Coast paid all premiums and fees directly to Blue Cross. In addition, Coast paid 75% of the premiums owed by each eligible

employee. The employees paid the remaining 25% of their premiums through payroll deductions, which were administered by Coast. As mentioned, these facts are not in dispute.

No insurance contract or policy was made or entered into between Blue Cross and Charlie, Janette or Richard Kornman ("Kornmans"). The insurance in this matter was provided by Blue Cross to Coast and its medical expense plan ("Coast MEP") and not to the Kornmans. Coast provided medical benefits to Charlie Kornman and his wife, Janette Kornman, only by virtue of the fact that Charlie Kornman was an employee of Coast who enrolled in the medical expense plan established by Coast. Coast, as noted above, paid 75% of the premiums due Blue Cross and controlled and administered all funds deducted from employees' paychecks to pay the remaining 25% of premiums due. Coast further assumed responsibility for submitting the premium payments to Blue Cross. Charlie Kornman was only one of twenty (20) or more of Coast employees who became participants and beneficiaries of the Coast Medical Expense Plan ("Coast MEP"). These facts are also undisputed.

In their pleadings, Charlie and Janette Kornman allege that pursuant to Louisiana law Blue Cross is liable for medical expenses incurred by Richard Kornman as a result of his eleven month stay (from May, 1987 to April, 1988) at Coliseum Medical Center ("Coliseum") and his treatment there for alleged drug use and abuse. It is undisputed that Blue Cross had no previous knowledge of Richard Kornman's drug problem until it received the claim, which is the subject matter of this case, for Richard Kornman's confinement at Coliseum.

Richard Kornman was born on December 2, 1959. At the time of his treatment, at Coliseum Medical Center, Richard Kornman was 27 years old. The Kornmans allege that Richard

Kornman was a dependent of Charlie and Janette Kornman during his confinement.

The position of Blue Cross relative to the medical expense plan established by Coast for its employees is that it was a medical benefit plan under the Employee Retirement Income Security Act (ERISA) because it involved a program established or maintained by an employer for the purpose of providing health benefits for the employee through the purchase of insurance or otherwise. 29 U.S.C. §1002(1) Blue Cross determined that the Coast MEP insured by Blue Cross did not provide coverage for the claims made by the Kornmans for Richard Kornman's treatment at Coliseum.

Thereafter, the Kornmans brought suit in the Twenty-Fourth Judicial District Court for the Parish of Jefferson, State of Louisiana. In said suit, the Kornmans requested penalties and attorney fees which they alleged they were entitled to under Louisiana law. Blue Cross removed the Kornmans' suit to the United States District Court for the Eastern District of Louisiana on the ground that it was a matter governed by the Employee Retirement Income Security Act (ERISA) 29 U.S.C. §1001, et seq.; 29 U.S.C. §1002(1); 29 U.S.C. §1132(a)(1)(B), and that plaintiffs' claims were preempted by ERISA. Specifically and as mentioned above, it is Blue Cross' position that the medical expense plan at issue in this matter provided by Coast to its employees and insured by Blue Cross is "an employee welfare benefit plan" as defined by ERISA, 29 U.S.C. §1002(1), and ERISA, 29 U.S.C. §1144 preempts the Louisiana law under which the Kornmans' make their claim, including Louisiana the law providing for penalties and attorneys' fees.

The Kornmans thereafter filed a Motion to Remand contending that the Coast MEP was not an ERISA plan. The

Judge in the U.S. District Court when he considered Kornmans' Motion to Remand did not hold any hearings, take any evidence or provide counsel for Blue Cross an opportunity to argue opposition to the Motion to Remand. He simply decided the matter on briefs and ordered the Kornmans' suit remanded to the 24th Judicial District Court, Parish of Jefferson, State of Louisiana. (Appendix C) The Judge in the U.S. District Court did not have before him the undisputed facts that Coast arranged the plan, determined what medical benefits the plan would provide, and determined that the plan would be insured by Blue Cross and what would be insured by Blue Cross. Coast was billed directly for all premiums and fees due under the agreement with Blue Cross, and Coast paid all premiums and fees directly to Blue Cross. Further, Coast paid 75% of the premiums owed by the 20 or more eligible employees who participated in the plan, and the employees paid the remaining 25% of their premium through payroll deductions which were administered by Coast. The Judge in the U.S. District Court did not have before him the above undisputed involvement of Coast with the medical expense plan for its employees.

The Judge in the United States District Court made his decision to remand this case to the state court relying on the case of Taggart Corp. v. Life & Health Benefits Administration, Inc., 617 F.2d 1208 (5th Cir. 1980) cert. denied 450 U.S. 1030 (1981) which was the only United States Court of Appeal, Fifth Circuit, case available as precedent for the judge in the U.S. District Court to consider. However, since that time, the United States Court of Appeal has promulgated several other cases which limit Taggart, supra. to its particular facts and which later cases further define, in the United States Court of Appeal, Fifth Circuit's opinion, what constitutes an ERISA plan. See Memorial Hospital Sys. v. Northbrook Life Insurance Co., 904 F.2d 236, 242-43 (5th Cir. 1990); Rodriguez v. Pacificare of Texas, Inc., 980 F.2d 1014, 1016-17, n. 2 (5th Circ. 1993); Kidder v. H & B Marine,

Inc., 932 F.2d 347 (5th Cir. 1991), Hansen v. Continental Ins. Co., 940 F.2d 971 (5th Cir. 1991). The United States Court of Appeals, Fifth Circuit, has determined in these later cases what standards and/or guidelines it uses to determine if an employer established medical plan for its employees is an ERISA plan. The Fifth Circuit uses as a guideline the employer's involvement with and relationship to the plan.

Following the remand of the Kornmans' suit to the Twenty-Fourth Judicial District Court for the Parish of Jefferson, State of Louisiana, the trial court, Blue Cross filed exceptions and a memorandum in support of the exceptions (Appendix H) in order to preserve its argument and the federal question that the Coast MEP was an ERISA plan. Blue Cross further argued, *inter alia*, that since the Coast MEP was an ERISA plan, ERISA governed this matter, and that the Kornmans had failed to join a necessary party, i.e. the Coast MEP, the Kornmans' suit was premature and the Kornmans' claims were preempted by ERISA. (Appendix H) The Twenty-Fourth Judicial District Court, the trial court, without written reasons rendered a judgment denying the Exceptions. (Appendix D)

Following trial of this matter, during which, petitioner, Blue Cross continued its argument that the Coast MEP was an ERISA plan, the Twenty-Fourth Judicial District Court, Parish of Jefferson, State of Louisiana, held for the Kornmans and awarded them judgment. From that judgment, Blue Cross took an appeal to the Louisiana Court of Appeal, Fifth Circuit. In order to continue to preserve its argument and the federal question that the Coast MEP was an ERISA plan, petitioner, Blue Cross, took the appeal to the Louisiana Court of Appeal, Fifth Circuit, for the reasons set forth in its brief (Appendix F), including but not limited to, that the Twenty-Fourth Judicial District Court, Parish of Jefferson, State of Louisiana, erred in not holding that the medical expense plan established by Coast

for its employees ("Coast MEP") was an ERISA plan and therefore the claims of the Kornmans were preempted, the Coast MEP was an indispensable party, the Kornmans' suit was premature, and the Kornmans were not entitled to penalties under ERISA.

The Court of Appeal, Fifth Circuit, affirmed the Judgment of the 24th Judicial District Court, the trial court, holding that it would not follow the decisions made and guidelines and standards used and established by the United States Court of Appeal, Fifth Circuit, in Memorial Hospital Sys., supra, Kidder, supra, and Hansen v. Continental Insurance Company, supra. Consequently, the Court held that the Coast MEP was not an employee medical expense plan, and ERISA plan, as defined by the Employee Retirement Income Security Act (ERISA). The Louisiana Court of Appeal, Fifth Circuit, further said in its opinion that the factual distinction made by the United States Court of Appeal, Fifth Circuit, of the Taggart case, supra, was "inappropriate". In its decision, the Louisiana Court of Appeals, Fifth Circuit, further said that since the Coast MEP was not an ERISA plan, it did not have to consider the Blue Cross arguments relative to preemption, failure to exhaust administrative remedies, failure to join an indispensable party and penalties. (Appendix B)

Thereafter, petitioner, Blue Cross, made a timely application for rehearing to the Louisiana Court of Appeal, Fifth Circuit and continued to argue that the Coast MEP was an ERISA plan. (Appendix G) However, the Louisiana Court of Appeal, Fifth Circuit, refused to grant a rehearing to petitioner, Blue Cross (Appendix E).

Petitioner, Blue Cross, thereafter made application to the Supreme Court of the State of Louisiana, the state court of last resort, for a writ of certiorari and/or review of the judgment of the

Louisiana Court of Appeal, Fifth Circuit. In said application for writ of certiorari and/or review (Appendix K), petitioner, Blue Cross, continued to argue, among other things, that the Coast MEP for its employees was an ERISA plan and that the Supreme Court of the State of Louisiana should grant the writ of certiorari and/or review and reverse the Louisiana Court of Appeal, Fifth Circuit and find that the Coast MEP was an ERISA plan and consider the issues of preemption, failure to exhaust administrative remedies, failure to join an indispensable party and penalties or remand the case to the Louisiana Court of Appeal, Fifth Circuit, to decide these issues. The Supreme Court of the State of Louisiana, however, denied the application for writ of certiorari and/or review of Blue Cross on February 16, 1996, (Appendix A). The Supreme Court of the State of Louisiana pursuant to its rules will not consider an application for rehearing when the Court denies an application for a writ of certiorari and/or review. Louisiana Supreme Court Rules, Rule IX, Section 6 which states:

> **Section 6.** An application for rehearing will not be considered when the court has merely granted or denied an application for a writ of certiorari or a remedial or other supervisory writ, or when the judgment of this court is merely overruling a motion to dismiss an appeal or a motion to recall or rescind a rule nisi . . ."

The Supreme Court of the State of Louisiana is the court of last resort in the State of Louisiana and therefore Blue Cross files this petition and requests this Honorable Court to grant a writ of certiorari to review an important federal question decided by a Louisiana state court of last resort that conflicts with decisions of a United States Court of Appeal and further for the reason that a Louisiana court has decided an important question of federal law that has not been, but should be settled by this Honorable Court.

ARGUMENT AND REASONS FOR GRANTING THE PETITION FOR WRIT OF CERTIORARI

There is now a conflict between a decision in the Louisiana courts and decisions of a United States Court of Appeal. This conflict arises as a result of the decision and judgment of the Louisiana Court of Appeal, Fifth Circuit, (Appendix B) and the denial by the Supreme Court of the State of Louisiana, the state court of last resort, of a writ of certiorari and/or review to review that decision (Appendix A).

In its decision in this case (Appendix B) that causes this conflict, the Louisiana Court of Appeal, Fifth Circuit, states:

> On remand, appellant reurged its argument to the state trial court that ERISA applied. Adopting the reasons set forth in the Eastern District Court's order, the trial court likewise found ERISA did not apply.
>
> On appeal, despite the findings of both the Eastern District Court and the state trial court, Blue Cross continues to assert ERISA governs this case.[4] Blue Cross bases its argument on recent federal Fifth Circuit cases[5], de-

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[4] If ERISA applies, plaintiffs would be prevented by federal preemption from recovering penalties allowed under state law for an insurer's arbitrary and capricious failure to pay a claim. See Cramer v. Association Life Ins. Co., 569 So.2d 533 (La. 1990); cert. denied, 499 U.S.. 938, 111 S.Ct. 1391, 113 L.Ed.2d 447 (1991).

[5] These cases include Hansen v. Continental Ins. Co., 940 F.2d 971 (5th Cir. 1991); Kidder v. H & B Marine Inc., 932 F.2d 347 (5th Cir. 1991); and Memorial Hospital System v. Northbrook Life Ins. Co., 904 F.2d 236 (5th Cir. 1990).

cided after the 1988 Eastern District Court's order of remand, which severely restrict Taggart Corp. v. Life & Health Benefits Admin., supra, the sole case relied on by both the Eastern District Court and the trial court in determining Coast's MEP was not an ERISA plan. Blue Cross asserts Coast's MEP would qualify as an ERISA plan under the guidelines established by these new federal cases. However, plaintiffs argue the new federal cases cannot be retroactively applied because to do so would divest them of a vested right, namely the right to penalties and attorney's fees, given them as a matter of state law.[6]

In matters involving federal law, we, as a state court, are only "bound" by decisions of the United States Supreme Court. Gaspard v. Transworld Drilling Co., 468 So.2d 692 (La. App. 3 Cir. 1985), writ denied, 474 So.2d 1304 (La. 1985), cert. denied, 475 U.S. 1067, 106 S.Ct. 1382, 89 L.Ed.2d 607 (1986). Federal appellate court decisions, such as decisions rendered by the Federal Fifth Circuit, are merely persuasive. State v. White, 321 So.2d 491 (La. 1975). As a state court, we have authority to render decisions based on our own interpretation of federal law provided federal courts do not have exclusive jurisdiction over the matter. Asarco Inc. v. Kadish, 490 U.S. 605, 109 S.Ct. 2037, 104 L.Ed.2d 696 (1989). Thus, since we share concurrent jurisdiction

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6 We note the only cause of action affected by the application of ERISA is for the recovery of penalties because attorney's fees may be recovered under ERISA. See 29 USC §1132(g)(1) which provides, ". . . the court in its discretion may allow a reasonable attorney's fee and costs of action to either party."

with federal courts over ERISA matters[7], we are not technically bound by the newer federal cases relied upon by appellant.

The Employee Retirement Income Security Act (ERISA) was enacted in 1974 for the purpose of protecting workers participating in employee benefit plans from misappropriation and misuse of funds paid into the plan and other abuses by regulating the administration of the plans. 29 U.S.C. §1001(b).[8] ERISA applies to any "employee benefit plan" established or maintained by any employer or employee organization engaged in commerce, or in any industry or activity affecting commerce. 29 U.S.C. §1003(a). While ERISA regulates two types of benefit programs, pension plans and welfare plans, our concern is with the welfare plan. An "employee welfare benefit plan" is defined as

(1) the terms "employee welfare benefit plan" and "welfare plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training pro-

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7 See 29 USC §1332(e)(1).

8 See also, Comments, *Small Employers and Group Health Insurance: Should ERISA Apply*?, 52 La.L.Rev. 971 (1992).

grams, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 186(c) or this title (other than pensions on retirement or death, and insurance to provide such pensions).

29 U.S.C. §1002(1)

There have been many cases which have attempted to set forth guidelines to determine whether a particular insurance arrangement constitutes an "employee welfare benefit plan." In 1980, the federal Fifth Circuit held that "bare purchases of health insurance where . . . the purchasing employer neither directly nor indirectly owns, controls, administers or assumes responsibility for the policy or its benefits" are not governed by ERISA. Taggart Corp. v. Life & Health Benefits Admin., supra. In deciding Taggart the Court was careful to consider ERISA's purpose and legislative history. The Court determined ERISA's purpose would not be served in the Taggart case because the plan at issue did not have any assets which ERISA's safeguards were intended to protect.

However, since 1980, the federal Fifth Circuit has severely limited the Taggart holding by factually distinguishing Taggart on the fact it involved a corporation with only one employee who was essentially purchasing insurance for himself and his family, as opposed to purchasing insurance for a group of employees, through a multiple employer trust. We find this factual distinction as the reason for the more recent federal Fifth Circuit cases not to follow Taggart inappropriate. The factual distinction disregards the purpose and legislative history of ERISA which was so carefully considered by the Court in Taggart.

> The later federal cases, while refusing to overrule the "bare purchase" analysis of Taggart, hold that the purchase of a group policy along with the payment of premiums offers "substantial evidence" that a plan has been established. But, the Court admits the mere payment of premiums is insufficient to create an ERISA plan. See Kidder v. H&B Marine, Inc., 932 F.2d 347 (5th Cir. 1991), and Memorial Hosp. System v. Northbrook Life Ins. Co., 904 F.2d 236 (5th Cir. 1990). In focusing on the employer-employee-plan relationship, the Fifth Circuit Court has apparently abandoned its focus on whether the "plan" is a trust that has assets which are to be protected by the ERISA safeguards.
>
> Because we believe the later federal Fifth Circuit cases are not in accord with Congressional intent, we decline to follow them and instead adhere to the "bare purchase" rationale of Taggart without making what appears to be inconsequential factual distinctions. In Taggart, the employer purchased a group insurance policy through a multiple employers trust (MEP). The employer paid its premiums to the MET which in turn forwarded the premiums to an insurer. The employer did not participate in the day-to-day operations or administration of the MET.
>
> (emphasis ours)

This Honorable Court should grant this petition for writ of certiorari and now resolve this conflict between the Louisiana courts and the United States Court of Appeal, Fifth Circuit, as to whether the guidelines and/or standards as set forth by the United States Court of Appeal, Fifth Circuit, in the cases of Memorial Hospital Sys., 904 F.2d 236, Rodriguez, 980 F.2d 1014, Kidder,

932 F.2d 347 and Hansen, 940 F.2d 971, are appropriate guidelines and standards to follow in determining whether a medical expense plan provided by an employer to its employees is an ERISA plan to be governed by the Employee Retirement Income Security Act 29 U.S.C. §1001, et seq. (ERISA) The Louisiana court in its decision says it would be bound by the decision of this Honorable Court, the United States Supreme Court. The Louisiana court says it is not bound by decisions of the United States Court of Appeal and will not follow those decision on this important federal question. The guidelines and/or standards to follow in making a determination as to what medical expense plans are ERISA plans is an important federal question of law that has not been, but should be, settled by this Honorable Court.

This Honorable Court should also resolve the conflict as to whether the factual distinctions made by the United States Court of Appeal, Fifth Circuit, in the Memorial Hospital Sys. case, supra and later cases are appropriate to limit the Taggart case, supra to its facts -- or are these factual distinctions "inappropriate" as decided by the Louisiana court.

The undisputed facts in this case show without any doubt that the Coast MEP for its employees met all of the guidelines and standards set out by the United States Court of Appeal, Fifth Circuit, in Hansen, 940 F.2d 971 (5th Cir. 1991), Memorial Hospital Sys., 904 F.2d 236 (5th Cir. 1990); and Rodriguez, 980 F.2d 1014 (5th Cir. 1993). The Coast MEP was not excluded from being covered by ERISA by Department of Labor Regulations 29 C.F.R. 2510.3(j)(1) since Coast, the employer, made significant contributions to the health plan. Coast paid 75% of the employees' premiums.

The focus guidelines used by the United States Court of Appeal, Fifth Circuit, in determining whether a medical expense plan is an ERISA plan is the employer's involvement in the plan.

See, Memorial Hosp. Sys., supra, at pages 242-43; Rodriguez, supra, at pages 1016-17, n.2.

In Rodriguez, the employees contributed, through payroll deductions, a portion of the insurance premiums; the employer paid the balance. The Fifth Circuit specifically held in Rodriguez that such an arrangement and involvement by the employer established an ERISA plan. Rodriguez, 980 F.2d at 1017, n.2. Likewise, a similar arrangement by the employer was found sufficient in the Memorial Hospital case to establish an ERISA plan. Memorial Hospital, 904 F.2d at 242-43. The facts are undisputed in this case as to the employer's, Coast Quality Construction Co., involvement in the medical expense plan it provided for its employees, one of which was Charlie Kornman. Coast arranged for the plan, chose the coverage the plan would provide to its employees, chose to insure the plan, selected Blue Cross to insure the plan. Further, Coast paid a percentage of each employee's premium and deducted the remaining percentage from each employee's paycheck through payroll deductions. Additionally, Coast controlled and administered all funds deducted from employee's paychecks, assumed responsibility for any balance due Blue Cross for premiums. Certainly Coast, the employer, established and maintained the plan.

In addition, the plan further provided that if an employee disputed a decision as to coverage or payment of a claim, then the employee might appeal to the ERISA Review Department at Blue Cross (Appendix I). All of these facts are undisputed and brought out at the trial and contained in the trial record. Transcript at pp. 987-989 and p. 1730.

The Taggart case, supra, would not be applicable to this case because:

(1) Unlike the Taggart case where there was only one employee, Charlie Kornman was one of twenty (20) or more employees of Coast enrolled in the Coast MEP and not the only employee of Coast enrolled in the medical expense plan as was the case in Taggart.

(2) Unlike the Taggart case, this case does not involve the bare purchase of insurance. Coast, and not a trust entity as in Taggart, was very involved with the medical expense plan as follows:

(a) Coast chose to provide health benefits for its employees and arranged for the plan;

(b) Coast chose the coverage the plan and its insurer would provide to its employees;

(c) Coast paid a percentage of each employee's premium;

(d) Coast deducted the remaining percentage from each employee's paycheck through payroll deductions;

(e) Coast controlled and administered all funds deducted from employee's paychecks;

(f) Coast assumed responsibility for submitting the premium payments to Blue Cross each month; and

(g) Coast assumed responsibility for the balance of the premiums.

The medical expense plan established by Coast for its employees had assets to protect and those assets should be protected by ERISA. Coast and the medical expense plan it established had a fiduciary relationship with its employees who were participants in and members of the medical expense plan, and Coast had a trust of their funds. Coast deducted for the medical expense plan a percentage from each employees pay check through payroll deductions to pay for each employees premium due for participation in the medical expense plan. Coast itself paid the remaining percentage, i.e. 75%, due for each employees premium. Coast controlled and administered for the medical expense plan all funds deducted from employees' pay checks and controlled and administered its own funds to pay premiums. Coast assumed responsibility of the medical expense plan for submitting the premium payments to Blue Cross each month. Coast assumed responsibility for the balance of the premiums due by the medical expense plan. Coast thus established a trust of employee funds and Coast funds to pay premiums due by the medical expense plan. The medical expense plan and Coast had a trust and fiduciary responsibility to Coast employees and the medical expense plan for its employees that ERISA is intended and meant to protect and should protect. Even if there was no "formal" trust or trust fund, one is not required since the Coast MEP was an insured plan. 29 U.S.C.§1103(b)(1), Memorial Hosp. Sys. v. Northbrook Life Ins. Co., 904 F.2d 236,n.2 (5th Cir. 1990).

It is submitted that this petition for writ of certiorari should be granted to secure uniformity of jurisprudence. Medical expense plans established by employers for their employees with the same set of facts as this case litigated in the United States courts will be determined to be ERISA medical expense plans. However, since the Louisiana Court of Appeal, Fifth Circuit has held that it will not follow the decisions of the United States

Court of Appeal, Fifth Circuit, in the Hansen, Memorial Hospital Sys., Rodriguez and Kidder cases and since the Supreme Court of the State of Louisiana, the court of last resort, has denied an application for writ of certiorari to review the decision of the Louisiana Court of Appeal, these same medical expense plans if litigated in Louisiana courts will be held not to be ERISA medical expense plans. Because of this conflict, there will be unsettling results and confusion. Employers, as well as employees in Louisiana, will not know whether or not they have, or are participants in, an ERISA medical expense plan. There will be no uniformity of jurisprudence and great confusion between the Louisiana courts and the United States courts if this Honorable Court does not resolve this conflict in decisions. The law on ERISA should be the same in state courts and the United States courts.

CONCLUSION

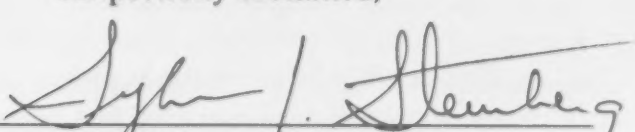
This conflict between the Supreme Court of the State of Louisiana, the Louisiana court of last resort, and the United States Court of Appeal, Fifth Circuit, is an important federal question which has not been, but should be, settled by this Honorable Court. The United States Court of Appeal, Fifth Circuit's, guidelines and/or standards used to determine whether a medical expense plan provided by an employer to its employees is an ERISA plan to be governed by the Employee Retirement Income Security Act, 29 U.S.C. §1001, et seq. is in direct conflict with the Louisiana Court of Appeal, Fifth Circuit's decision that it will not follow the guidelines and/or standards established by the United States Court of Appeal, Fifth Circuit.

This Honorable Court should resolve this conflict and determine if the guidelines and standards established by the United States Court of Appeal, Fifth Circuit, are appropriate guidelines to use to determine if a medical expense plan estab-

lished by an employer for its employees is an ERISA plan. If they are appropriate guidelines, then this Honorable Court may determine that the Coast MEP was an ERISA plan and remand the case for a determination of the issues of preemption, failure to exhaust administrative remedies, failure to join an indispensable party, and penalties pursuant to ERISA. Or, this Honorable Court may remand the case for determination that the Coast MEP was an ERISA plan under the guidelines established by the United States Court of Appeal, Fifth Circuit, and also the issues of preemption, failure to exhaust administrative remedies, failure to join an indispensable party and penalties.

For these reasons, it is respectfully requested that this Honorable Court grant petitioner's request for writ of certiorari.

Respectfully submitted,



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APPENDIX A

THE SUPREME COURT OF THE STATE OF LOUISIANA

JANETTE M. wife of/and
CHARLIE KORNMAN, INDIVIDUALLY AND ON BEHALF OF THEIR DEPENDENT SON
RICHARD JAY KORNMAN

VS. NO. 95-C-3025

BLUE CROSS/BLUE SHIELD
OF LOUISIANA

IN RE: Blue Cross Blue Shield of La.; Louisiana Health Serv. & Indem.; - Defendant(s); Applying for Writ of Certiorari and/or Review; to the Court of Appeal, Fifth Circuit, Number 94-CA-0306; Parish of Jefferson 24th Judicial District Court Div. "E" Number 364-688

February 16, 1996

Denied.

WFM

PFC

JCW

HTL

BJJ

JPV

KIMBALL, J. recused.

Supreme Court of Louisiana
February 16, 1996

s/John Tarlton Olivier
Acting Clerk of Court
For the Court

APPENDIX B

JANETTE M. wife of/and CHARLIE KORNMAN, INDIVIDUALLY AND ON BEHALF OF THEIR DEPENDENT SON, RICHARD JAY KORNMAN	* NO. 94-CA-306 * COURT OF APPEAL * FIFTH CIRCUIT
VERSUS	* STATE OF LOUISIANA
BLUE CROSS/BLUE SHIELD OF LOUISIANA	

APPEAL FROM THE 24TH JUDICIAL DISTRICT COURT
PARISH OF JEFFERSON, STATE OF LOUISIANA,
DIVISION "E", DOCKET NUMBER 364-688
HONORABLE CLARENCE E. MCMANUS, JUDGE

CHARLES GRISBAUM, JR.

JUDGE

SEPTEMBER 26, 1995

(Court composed of Judges Charles Grisbaum, Jr.
Thomas C. Wicker, Jr., and Sol Gothard)

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AFFIRMED

INTRODUCTION

Defendant appeals from the trial court's judgment finding plaintiffs were entitled to benefits for Richard Kornman's 11-month confinement/treatment for drug abuse under the health insurance policy provided by defendant along with penalties and attorney's fees. We affirm.

ISSUES

1. Whether the Coast Quality Construction Company's (Coast) Medical Expense Plan (MEP) is a plan under the Employee Retirement Income Security Act (ERISA);

2. Whether Richard was covered as a dependent under Coast's MEP;

    a. Whether Richard Kornman was capable of self-support;

    b. Whether Charlie Kornman was required to provide proof of Richard's incapacity of dependency when Richard reached age 25; the limiting age;

    c. Whether Blue Cross could have denied Richard's coverage based on information in a health questionnaire;

3. Whether Richard Kornman's treatment at Coliseum was covered by the terms of the policy;

    a. Whether Richard's treatment at the Coliseum fell during the 365-day exclusion period for pre-existing conditions;

    b. Whether Richard was treated for substance abuse or for a mental condition for which there is a policy limit of $5,000;

    c. Whether Richard's treatment at the Coliseum Medical Center was medically necessary.

FACTS

Plaintiffs, Charlie, Janette and Richard Kornman[1], filed suit in state court in June 1988 against Blue Cross/Blue Shield of

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[1] Since filing suit, Charlie Kornman passed away and his estate was substituted as a plaintiff. Additionally, Richard Kornman, was added as a plaintiff after the suit was initially filed.

Louisiana[2] (Blue Cross), seeking medical benefits allegedly owed them under a medical expense plan (MEP) established by their employer, Coast Quality Construction Company (Coast), and insured by defendant. Charlie Kornman was both the owner and an employee of Coast.

Plaintiffs seek recovery for medical expenses incurred by Richard Kornman during an eleven-month stay at the Coliseum Medical Center ("Coliseum"), for treatment for substance abuse. Plaintiffs maintain Richard was covered as a dependent under Charlie Kornman's policy. Alternatively, plaintiffs maintain Richard was covered independently as an employee of Coast. Blue Cross denied coverage under both assertions.

Blue Cross attempted to remove the matter to federal court on the basis ERISA governed but the Eastern District Court found there was no ERISA plan and remanded the matter to the state court. After a sporadic four day trial, the trial court found ERISA did not apply, Richard was covered by Blue Cross as Charlie's dependent and was, accordingly, owed benefits. The trial court awarded plaintiffs $174,423.64 for benefits, $37,940.25 for attorney's fees, $174,423.64 in penalties, $16,351.02 in costs and exert fees, plus interest. Blue Cross appeals this judgment on several grounds.

ISSUE ONE: Is Coast's MEP an ERISA plan?

On July 21, 1988, defendant-appellant filed a petition of removal on the basis plaintiffs' cause of action for the recovery of benefits under Coast's medical expense plan (MEP) was

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[2] Defendant, Louisiana Health Service & Indemnity Company, was erroneously named by plaintiffs as Blue Cross/Blue Shield of Louisiana. However, for purposes of this appeal, we will refer to defendant-appellant as Blue Cross.

governed by ERISA and, thus, a federal question existed for federal court jurisdiction. The United States District Court for the Eastern District of Louisiana remanded the matter finding Coast's MEP did not qualify as an ERISA plan under Taggart Corp. v. Life & Health Benefits Admin., 617 F.2d 1208 (5th Cir. 1980), cert. denied, 450 U.S. 1030 (1981).[3]

On remand, appellant reurged its argument to the state trial court that ERISA applied. Adopting the reasons set forth in the Eastern District Court's order, the trial court likewise found ERISA did not apply.

On appeal, despite the findings of both the Eastern District Court and the state trial court, Blue Cross continues to assert ERISA governs this case.[4] Blue Cross bases its argument on recent federal Fifth Circuit cases[5], decided after the 1988 Eastern District Court's order of remand, which severely restrict Taggart Corp. v. Life & Health Benefits Admin., supra, the sole case relied on by both the Eastern District Court and the trial

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[3] We note the order of remand is not included in the appellate record. However, appellees attached a copy of the Eastern District Court's order and reasons dated October 21, 1988 to their brief which shows the Court found the plan in question was not an ERISA plan.

[4] If ERISA applies, plaintiffs would be prevented by federal preemption from recovering penalties allowed under state law for an insurer's arbitrary and capricious failure to pay a claim. See Cramer v. Association Life Ins. Co., 569 So.2d 533 (La. 1990); cert. denied, 499 U.S.. 938, 111 S.Ct. 1391, 113 L.Ed.2d 447 (1991).

[5] These cases include Hansen v. Continental Ins. Co., 940 F.2d 971 (5th Cir. 1991); Kidder v. H & B Marine Inc., 932 F.2d 347 (5th Cir. 1991); and Memorial Hospital System v. Northbrook Life Ins. Co., 904 F.2d 236 (5th Cir. 1990).

court in determining Coast's MEP was not an ERISA plan. Blue Cross asserts Coast's MEP would qualify as an ERISA plan under the guidelines established by these new federal cases. However, plaintiffs argue the new federal cases cannot be retroactively applied because to do so would divest them of a vested right, namely the right to penalties and attorney's fees, given them as a matter of state law.[6]

In matters involving federal law, we, as a state court, are only "bound" by decisions of the United States Supreme Court. Gaspard v. Transworld Drilling Co., 468 So.2d 692 (La. App. 3 Cir. 1985), writ denied, 474 So.2d 1304 (La. 1985), cert. denied, 475 U.S. 1067, 106 S.Ct. 1382, 89 L.Ed.2d 607 (1986). Federal appellate court decisions, such as decisions rendered by the Federal Fifth Circuit, are merely persuasive. State v. White, 321 So.2d 491 (La. 1975). As a state court, we have authority to render decisions based on our own interpretation of federal law provided federal courts do not have exclusive jurisdiction over the matter. Asarco Inc. v. Kadish, 490 U.S. 605, 109 S.Ct. 2037, 104 L.Ed.2d 696 (1989). Thus, since we share concurrent jurisdiction with federal courts over ERISA matters[7], we are not technically bound by the newer federal cases relied upon by appellant.

The Employee Retirement Income Security Act (ERISA) was enacted in 1974 for the purpose of protecting workers participating in employee benefit plans from misappropriation

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6 We note the only cause of action affected by the application of ERISA is for the recovery of penalties because attorney's fees may be recovered under ERISA. See 29 USC §1132(g)(1) which provides, ". . . the court in its discretion may allow a reasonable attorney's fee and costs of action to either party."

7 See 29 USC §1332(e)(1).

and misuse of funds paid into the plan and other abuses by regulating the administration of the plans. 29 USC §1001(b).[8] ERISA applies to any "employee benefit plan" established or maintained by any employer or employee organization engaged in commerce, or in any industry or activity affecting commerce. 29 USC §1003(a). While ERISA regulates two types of benefit programs, pension plans and welfare plans, our concern is with the welfare plan. An "employee welfare benefit plan" is defined as

> (1) the terms "employee welfare benefit plan" and "welfare plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 186(c) or this title (other than pensions on retirement or death, and insurance to provide such pensions).
>
> 29 U.S.C. §1002(1)

There have been many cases which have attempted to set forth guidelines to determine whether a particular insurance

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[8] See also, Comments, *Small Employers and Group Health Insurance: Should ERISA Apply*?, 52 La.L.Rev. 971 (1992).

arrangement constitutes an "employee welfare benefit plan." In 1980, the federal Fifth Circuit held that "bare purchases of health insurance where . . . the purchasing employer neither directly nor indirectly owns, controls, administers or assumes responsibility for the policy or its benefits" are not governed by ERISA. Taggart Corp. v. Life & Health Benefits Admin., supra. In deciding Taggart the Court was careful to consider ERISA's purpose and legislative history. The Court determined ERISA's purpose would not be served in the Taggart case because the plan at issue did not have any assets which ERISA's safeguards were intended to protect.

However, since 1980, the federal Fifth Circuit has severely limited the Taggart holding by factually distinguishing Taggart on the fact it involved a corporation with only one employee who was essentially purchasing insurance for himself and his family, as opposed to purchasing insurance for a group of employees, through a multiple employer trust. We find this factual distinction as the reason for the more recent federal Fifth Circuit cases not to follow Taggart inappropriate. The factual distinction disregards the purpose and legislative history of ERISA which was so carefully considered by the Court in Taggart.

The later federal cases, while refusing to overrule the "bare purchase" analysis of Taggart, hold that the purchase of a group policy along with the payment of premiums offers "substantial evidence" that a plan has been established. But, the Court admits the mere payment of premiums is insufficient to create an ERISA plan. See Kidder v. H&B Marine, Inc., 932 F.2d 347 (5th Cir. 1991), and Memorial Hosp. System v. Northbrook Life Ins. Co., 904 F.2d 236 (5th Cir. 1990). In focusing on the employer-employee-plan relationship, the Fifth Circuit Court has apparently abandoned its focus on whether the "plan" is a trust that has assets which are to be protected by the ERISA safeguards.

Because we believe the later federal Fifth Circuit cases are not in accord with Congressional intent, we decline to follow them and instead adhere to the "bare purchase" rationale of Taggart without making what appears to be inconsequential factual distinctions. In Taggart, the employer purchased a group insurance policy through a multiple employers trust (MET). The employer paid its premiums to the MET which in turn forwarded the premiums to an insurer. The employer did not participate in the day-to-day operations or administration of the MET.

In this case, Coast purchased a group insurance policy from a commercial insurance company, Blue Cross. Coast paid premiums directly to Blue Cross. Blue Cross controlled and administered the policy and its benefits. The group insurance policy was nothing more than a bare purchase of health insurance. There is no evidence Coast owned, controlled or assumed responsibility for the policy. Thus, we find Coast's MEP does not constitute an ERISA plan and, therefore, ERISA does not apply.[9]

ISSUE TWO: Was Richard Kornman covered as a dependent under the terms of the Blue Cross policy during his treatment at the Coliseum?

Coast changed its health insurance coverage from the Chamber plan to Blue Cross in July 1984. Under the Chamber plan, Richard was listed as a dependent of Charlie Kornman. When Coast first obtained group health insurance from Blue Cross, Charlie inadvertently failed to list Richard as a dependent.

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[9] Because we find ERISA does not apply, we need not address appellant's ERISA related issues of whether the Coast MEP is an indispensable party, whether plaintiffs' suit is premature for failure to exhaust administrative remedies provided for in the MEP and whether plaintiffs' state law claims for penalties is preempted by ERISA.

As a result, Carol Rodgers, the Coast employee in charge of the administrative aspects of the company's health insurance plan, sent a letter dated January 21, 1985 to Blue Cross requesting Richard be added as Charlie's dependent. Ten days later, the request was denied by Blue Cross.

We are presented with the question of whether Richard qualified as a dependent under the terms of the policies. The first Blue Cross policy, dated 1984, defined a dependent as:

> "Dependent" means a Member for whom current fees have been paid, and who is the Employee's spouse or a Member who depends on the Employee or his spouse for his support as either his:
>
> 1. Unmarried child under 19 years of age;
>
> 2. Unmarried child 19 to 25 years of age who is enrolled as a full time student;
>
> 3. Unmarried child who becomes mentally or physically disabled prior to attaining the limiting age stated in Article I, 1 and/or I, 2 above and/or who is incapable of self-support.
>
> A Member who depends upon the Employee or his spouse for his support must meet the criteria of I, 1 through 3 above, but, to the extent that the above criteria do not conflict, a Member must also qualify as the Employee's or Employee's spouse's Dependent for purposes of the most current calendar year's federal income tax laws and regulations.
>
> (Plaintiff's Exhibit 3).

The July 1985 Blue Cross policy defined a dependent as:

> "Dependent" means a Member for whom current fees have been paid and is:
>
> the Employee's legal spouse; and
>
> any unmarried child who:
>
> --- is under 19 years old;
>
> --- is 19 years old but less than 25 years old, if enrolled in school as a full-time student in a secondary school, college, university, vocational, technical, trade school or institute and primarily supported by the Employee.
>
> --- is mentally or physically disabled prior to attaining either one of the limiting ages shown above and who is incapable of self-support.
>
> --- qualifies as the Employee's or Employee's spouse's dependent for purposes of the most current calendar year's federal income tax laws and regulations.
>
> (Blue Cross' Exhibit 20).

And, the July 1987 Blue Cross policy definition of a dependent is identical to the 1984 definition.

Was Richard capable of self-support?

We do not see any substantial difference in the definition of a dependent between the policies. In July 1984, when Coast's

employees' health insurance was first covered by Blue Cross, Richard was 24 years old and not a full-time student. Therefore, the question is whether he was mentally or physically disabled and/or incapable of self-support. Plaintiffs assert "incapable of self support" refers to one's inability for self-sustaining employment. On the other hand, defendant maintains as long as a person has money on which to live, he is capable of self-support. There is no definition for "incapable of self-support" in the contract.

Plaintiffs maintain Richard had a drug problem since high school which rendered him incapable of self-support over the years prior to his hospitalization in that he could not hold a regular job, stay in school, or manage his money. Specifically, his mother, Janette Kornman, testified Richard was expelled from Country Day in high school for drug abuse in 1977. His drug abuse continued over the years and his parents sought help for him several times. Ms. Kornman explained Richard's sporadic job history. She stated she and her husband paid Richard's living expenses, including rent and food, and had to bail him our of his bills several times. Richard himself testified his meals and rent were provided by his parents and he would use any money he had to buy drugs. In summary, Mrs. Kornman testified Richard was never in any condition to support himself. Dr. Weisler, Richard's treating psychiatrist at the Coliseum, testified Richard's drug abuse affected his ability to manage his life. Dr. Weisler was of the opinion Richard was not capable of self-sustaining employment.

Defendant focuses on the fact Richard had a steady income over the years before his hospitalization and that income proves he is capable of self-support. However, the record shows the income was largely owed to his parents. Richard had bank accounts in his name which were set up by his father, Charlie. Richard did not have access to the accounts as they were controlled by his mother and father. Mrs. Kornman explained the

accounts were set up for each of the four kids to pay for college tuition and give the kids a head start on life when they finished school but the accounts were maintained and controlled strictly by her husband. The deposits into the accounts included dividend payments from companies set up by Charlie of which the kids were given a percentage. Furthermore, Richard testified when he made money, he spent it on drugs. Richard also stated the last few paychecks he received prior to entering the Coliseum were kept by his father.

The dictionary definition of self-support is "independent support of oneself." Webster's Collegiate Dictionary, Tenth Edition. Independent means not relying on something or someone else. The record shows Richard was financially supported by his parents. The record also shows his drug abuse impaired his ability to manage his life including his health and money. The mere fact Richard had accounts in his name with substantial amounts of money is not axiomatic for his ability to support himself. There is ample testimony showing Richard did not have access to the money. Without the money, he necessarily relied on his parents for food and payment of rent and other bills. Even if Richard had access to the money, we cannot say he was capable of self-support. He admitted the money he did have went to buying more drugs. Defendant points out Richard successfully attended a six-month kibbutz program in Israel where he remained drug free. However, we do not find a six-month period in 1980 to be indicative of whether Richard is capable of self-support in 1984, when the Blue Cross policy went into effect. Richard suffered from a drug addiction that severely impaired his ability to manage his life.

Defendant argues Richard still cannot be a dependent because he did not qualify nor was he claimed as a dependent on his parents' federal tax return as required by the policy. The language of the policy states "to the extent that the above criteria

do not conflict, a Member must also qualify as the Employee's . . . Dependent for purposes of the . . . federal income tax laws and regulations." Insofar as Richard could not qualify as a dependent for federal tax purposes, we find such federal provision conflicts with the policy and, therefore, according to the very terms of the policy, the provision is inapplicable.

Was Charlie Kornman required to provide proof of Richard's incapacity and dependency when Richard reached 25, the limiting age?

Defendant next maintains Charlie was required to provide proof of Richard's disability when Richard turned 25-years-old in December 1985 pursuant to La. R.S. 22:215.2(A). La. R.S. 22:215.2(A) provides:

> A. Any hospital or medical expense insurance policy delivered or issued for delivery in this state more than ninety days after July 12, 1973, which provides that coverage of a dependent child of an employee or other member of the covered group shall terminate upon attainment of the limiting age for dependent children specified in the policy shall also provide in substance that attainment of such limiting age shall not operate to terminate the coverage of such child while the child is and continues to be both (1) incapable of self sustaining employment, and (2) chiefly dependent upon the policyholder, employee or member for support and maintenance, provided proof of such incapacity and dependency is furnished to the insurer by the employee or member within thirty-one days of the child's attainment of the limiting age and subsequently as may be required by the insurer but not more frequently than annually after the two-year period following the

child's attainment of the limiting age.

We find the proof aspect of the statute was not the objective of the legislature in enacting the law but rather the primary intent was to require insurance companies to cover dependent children who have reached the limiting age for said children within the terms of the policy but who remain incapable of self-sustaining employment and are dependent for their support. The statute allows the insurance company to require proof of such incapacity and dependency as an ancillary. While Blue Cross included the requisite coverage, it did not mandate the proof element. We find Blue Cross effectively excluded the proof element of the statute and such exclusion does not thwart the intent of the law. Thus, Charlie was not required to provide proof of Richard's dependency where such proof was not requested by Blue Cross.

Could Blue Cross have denied Richard coverage based on information in a health questionnaire?

Defendant raises yet another issue regarding Richard's qualification as a dependent. Defendant asserts material misrepresentations were made by Charlie concerning Richard's prior health problems when he submitted the "Change of Status Form" attempting to add Richard as a dependent. Specifically, Byron Gorman, an insurance claims adjuster for Blue Cross, testified that had Richard's health questionnaire indicated he had a previous drug problem, he would have been rejected outright.

However, La. R.S. 22:215(A)(1)(a) precludes an insurer from issuing a group health insurance plan that allows for individual selection. Since Blue Cross could not legally exclude Richard from coverage, we find it unnecessary to determine whether material misrepresentations were made.

Having found Richard qualified as a dependent, we turn

our analysis to whether his treatment at the Coliseum was covered.[10]

ISSUE THREE: Was Richard's treatment at the Coliseum covered by the terms of the policy?

Did Richard's treatment at the Coliseum fall during the 365-day exclusion period for pre-existing conditions?

Defendant alternatively asserts if Richard was a qualified dependent, there was a 365-day waiting period for subsequent enrollees for pre-existing conditions. All three policies, 1984, 1985 and 1987, provided a 365-day waiting period for pre-existing conditions for subsequent enrollment which began to run from the original effective date. Mildred Echlin, an employee of Blue Cross, testified she reviewed Richard's claim and denied it because his treatment was for a pre-existing condition for which the time delays for coverage had not run.

Plaintiffs concede Richard was left off of Charlie's original enrollment application. Therefore, according to Ms. Echlin's testimony, Richard could not have been considered an initial enrollee and was thus subject to the delays for pre-existing conditions. We accept Richard was a subsequent enrollee subject to the 365-day waiting period for pre-existing conditions.

However, we have determined Richard qualified as a dependent under the July 1984 policy as well as the subsequent 1985 and 1987 policies. Therefore, Richard was a qualified dependent when Charlie sought to add him to his policy in January 1985 and should have been added as such. Thus, even

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[10] Because we determined Richard was a dependent under the policy, we find no need to address whether he was independently covered as an employee of Coast.

accepting defendant's argument there was a 365-day waiting period for coverage of Richard's pre-existing condition of substance abuse, that period expired in January 1986 at which time Richard was afforded full coverage. Richard was hospitalized in May 1987 through April 1988. It is clear Richard was afforded coverage for his treatment during the time he was hospitalized.

Was Richard treated for substance abuse or for a mental condition for which there is a policy limit of $5,000?

Defendant claims the maximum amount of benefits plaintiffs can recover is $5,000 because Richard's treatment was for a mental disorder for which there is a $5,000 policy limit. Since Richard was hospitalized in May 1987, the governing policy is the July 1985. The policy provided:

> After the applicable Comprehensive Medical Expense Deductible as shown in the Schedule of Benefits has been met, We agree to pay for the treatment of mental and nervous disorders, the coinsurance percentage shown in the Schedule of Benefits for mental and nervous incurred by each Member, not to exceed the applicable Limit of Liability shown for mental and nervous in the Schedule of Benefits.

Byron Gorman, a former employee of Blue Cross, testified the policy limits for a mental disorder was $5,000.

Dr. Weisler, Richard's treating psychiatrist at the Coliseum, testified drug abuse was the primary cause of Richard's problems which included at times psychotic like symptoms. Dr. Weisler further stated there were many symptoms that resulted from Richard's drug abuse including problems relating to people and managing his life. During cross-examination, Dr. Weisler was presented with some results of psychological tests concern-

ing Richard's condition. The tests indicated Richard suffered from some sort of psychotic illness which is a mental disorder. However, Dr. Weisler explained these tests are not a diagnosis but rather explain the condition of the patient. Although asked numerous times on cross-examination, Dr. Weisler emphatically denied Richard's condition as being one of a mental disorder. When Richard was admitted to the Coliseum, his records indicate his diagnosis was borderline personality disorder which Dr. Weisler admits is a mental disorder. However, we are convinced and accept the explanation of Dr. Weisler that Richard's primary problem was substance abuse which led to secondary problems. And while Richard may have been treated for secondary problems, we believe his primary treatment was for substance abuse which is the reason he was judicially committed.

Was Richard's treatment at the Coliseum medically necessary?

The 1985 policy defines "medically necessary" as Health Care services which:

> are appropriate and consistent with the diagnosis and which, in accordance with accepted medical standards in the State of Louisiana, could not have been omitted without adversely and severely affecting the patient's condition;
>
> are not primarily Custodial Care;
>
> are appropriate and can be safely used under the circumstances. Inpatient Hospital Services should be used only when a lesser equipped facility (e.g. Outpatient Hospital Services, Physician's office, etc.) could adversely and severely affect the patient's condition.

The 1987 policy provided basically the same definition:

> "Medically Necessary" means a service or treatment which, in the judgment of the Plan:
>
> 1. Is appropriate and consistent with the diagnosis and which in accordance with accepted medical standards in the State of Louisiana could not have been omitted without adversely affecting the patient's condition or the quality of medical care rendered; and
>
> 2. Is not primarily Custodial Care; and
>
> 3. As to institutional care, could not have been provided in a Physician's office, in the Outpatient department of a Hospital, or in a lesser facility without adversely affecting the patient's condition or quality of medical care rendered.

In arguing Richard's treatment at the Coliseum was not medically necessary, defendant relies on the testimony of its expert, Dr. Olivier. However, we note Dr. Olivier's testimony was rejected by the trial court and is in the record through a proffer. However, defendant did not raise as an issue on appeal that the exclusion of Dr. Olivier's testimony was erroneous. Therefore, we cannot consider the proffered testimony.

Considering the record, we find Richard's treatment was medically necessary. It is absurd to argue Richard's condition would not have been adversely and severely affected if he had not received treatment at the Coliseum. Furthermore, after unsuccessfully being treated on an outpatient basis by various psychiatrists and doctors, we do not find Richard's condition could have been treated at a lesser facility.

CONCLUSION

We find Coast's MEP was not an ERISA plan. Later federal jurisprudence which severely restricts the holding of Taggart, which was relied on by the Eastern District and the trial court in determining Coast's MEP was not an ERISA plan, is not binding on us as a state court bur rather is merely persuasive. For the reasons above, we decline to follow the more recent federal jurisprudence due to our opinion it disregards the Congressional intent behind ERISA's enactment. We adhere to the rationale and the "bare purchase" test of Taggart and find Coast's MEP was nothing more than a bare purchase of health insurance for its employees.

After reviewing the terms of the Blue Cross policies, we find Richard Kornman was covered as a dependent of Charlie Kornman because he was incapable of self-support. Thus, Richard should have been added to Charlie's policy in January 1985 when he so requested it. We find proof of Richard's dependency was not required absent a request by Blue Cross. And, because we find Blue Cross could not have legally denied Richard coverage on the basis of his health, the issue of whether material misrepresentations were made on his health questionnaire is of no consequence.

Being added after the initial enrollment date of July 1984, Richard was a subsequent enrollee who was subject to the 365-day time delay for coverage of pre-existing conditions. However, the time delay had expired when Richard was hospitalized in May 1987. Thus, he was covered for treatment of substance abuse during the time he was hospitalized.

We find Richard's treatment was for substance abuse and not a mental disorder and, therefore, the policy limit of $5,000 for treatment of mental disorders is inapplicable. And, we find

Richard's treatment at the Coliseum was medically necessary as there was no evidence to the contrary.

For the above reasons, we hereby affirm *in toto* the trial court's judgment dated September 30, 1993 awarding judgment in favor of plaintiffs-appellees.

Appellant is to bear the costs for this appeal.

AFFIRMED

APPENDIX C

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF LOUISIANA

JANETTE M. KORNMAN, ET AL	CIVIL ACTION
V.	NO. 88-3102
BLUE CROSS/BLUE SHIELD OF LOUISIANA	SECTION "H" (4)

Order and Reasons

Plaintiffs filed suit in Louisiana state court for benefits allegedly due by defendant under a group insurance policy purchased by Coast Quality Construction Corporation for the benefit of its employees. The case was removed to this court by defendant on the ground that the action is governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. §1001 et seq. Plaintiffs maintain that the action is not governed by ERISA and move to remand the case to state court. For the following reasons, the motion is GRANTED.

The only issue presented by the motion is whether the insurance policy in question constitutes an "employee welfare benefit plan" within the meaning of ERISA. 29 U.S.C. §1002(1) defines "employee welfare benefit plan" as:

any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants, or their beneficiaries, through the

purchase of insurance or otherwise, . . . medical, surgical or hospital care or benefits, or benefits in the event of sickness accident, disability, death or unemployment. . . .

Plaintiffs contend that the insurance policy does not fall within that definition because it does not constitute a "plan, fund, or program." We agree.

The Fifth Circuit has squarely held that ERISA does not cover "bare purchases of health insurance where, as here, the purchasing employer neither directly nor indirectly owns, controls, administers or assumes responsibility for the policy or its benefits." Taggart Corp. v. Life & Health Benefits Administration, Inc., 617 F.2d 1208, 1211 (5th Cir. 1980), cert. denied, 450 U.S. 1030 (1981).

The defendant argues that the Taggart case is distinguishable because the employer in that case purchased the insurance through a multi-employer trust. However, in reaching its decision that the mere purchase of insurance did not constitute establishment of a "plan, fund, or program," the Taggart court did not rely on the fact that the insurance was purchased through a multi-employer group. The court's reasoning applies equally to this case. Moreover, defendant's argument raises a distinction without a difference. A purchase of insurance is not more a "plan, fund, or program" because accomplished unilaterally than it is if accomplished through a multi-employer group. In fact, if the distinction makes any difference, it cuts the other way; the existence of an organization as in Taggart to coordinate the purchase of insurance on behalf of a group of employers would make the case better suited to a finding of a "plan, fund, or program."

The defendant cites a number of cases from other circuits and urges the court to apply the reasoning of the Eleventh

Circuit's "seminal" decision in Donovan v. Dillingham, 688 F.2d 1367 (11th Cir. 1982) (en banc). Suffice it to say that, regardless of the law in other circuits, we are bound by the Fifth Circuit's decision in Taggart.

October 21, 1988

Adrian G. Duplantier
UNITED STATES
DISTRICT JUDGE

APPENDIX D

24TH JUDICIAL DISTRICT COURT FOR THE PARISH OF JEFFERSON

STATE OF LOUISIANA

NO.: 364-688 DIVISION "E"

JANETTE M., WIFE OF/AND CHARLIE KORNMAN, INDIVIDUALLY AND ON BEHALF OF THEIR DEPENDENT SON, RICHARD KORNMAN

VS.

BLUE CROSS/BLUE SHIELD OF LOUISIANA

FILED: _____ _____
DEPUTY CLERK

JUDGMENT

This matter came before the Court on Exceptions of No Cause or Right of Action, Lack of Procedural Capacity, Non-joinder of a Necessary Party Defendant, Prematurity and Lack of Subject Matter Jurisdiction, all filed on behalf of the defendant, Louisiana Health Service and Indemnity Company (Blue Cross/Blue Shield of Louisiana). A hearing was held on April 19, 1989.

PRESENT: DAVID C. LOEB AND
SUSAN M. CHEHARDY,
ATTORNEYS FOR PLAINTIFFS

SYLVAN J. STEINBERG AND
JULIA S. MANDELLA
ATTORNEYS FOR DEFENDANT

After considering the pleadings, memoranda and argument of counsel, it is hereby

ORDERED that the Exceptions filed herein on behalf of the defendant, Louisiana Health Service and Indemnity Company (Blue Cross/Blue Shield of Louisiana) be and the same are hereby denied.

IT IS FURTHER ORDERED that the defendant file responsive pleadings herein within fifteen (15) days of April 26, 1989.

Gretna, Louisiana, this 26 day of April, 1989.

s/Clarence E. McManus
JUDGE

APPENDIX E

COURT OF APPEAL, FIFTH CIRCUIT
State of Louisiana

Clerk's Office, Gretna November 17, 1995, 198____

DEAR SIR:

REHEARING WAS THIS DAY REFUSED IN THE CASE ENTITLED

Janette M. Kornman v. Blue Cross/Blue Shield of La.

No. 95 CA 310

Very truly yours,

PETER J. FITZGERALD, JR., Clerk